HIPAA CONSENT FORM FOR DR. PAUL ELLINGTON, DDS, PC

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent by requesting a copy from the receptionist. The terms of our Notice may change. If we change over Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this Consent. The Practice provides this form to comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA).

By signing this form, I understand that:

- **Protected health information (PHI) may be disclosed or used for treatment, payment of health care operations**
- **The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice**
- **The Practice reserves the right to change the Notice of Privacy Practices**
- **The patient has the right to restrict the use of their information, but the Practice does not have to agree to those restrictions**
- **The patient may revoke this Consent in writing at any time and all future disclosures will then cease**
- **The Practice may condition treatment upon execution of this Consent**

Below is a list of ways the office may contact you. Checking a box will give permission to leave, as thorough of a message as needed, from your dental office. This will include, but not limited to, appointment day, time and treatment scheduled, documents to be signed, financial and collection concerns or pre and post treatment directions. Any source other than the USPS, example: cell phones, email and fax lines, are not considered 100% secure. Contact information will be verified by patient.

______Patient gives office permission to use any contact written on patient registration form.

Please CIRCLE any that you DO want the office to call, we will be using the numbers/emails you have updated, on your Account information. All information is subject to availability to verify and validate.

Work Cell Work Phone Work Email Work Fax Mail to Work Personal Cell Home Phone Home Fax Home email Mail to Home Emergency Contact Any of these contacts

List names of who can have access to your dental/medical chart information and is allowed to be disclosed or copied.
CIRCLE TYPE BELOW:

____Financial, Treatment, Health History__________________________Phone number

____Financial, Treatment, Health History __________________________Phone number

_____Patient gives office permission to forward any verified contact information and PHI to patient's specialists. Office may discuss pertinent patient chart information, including PHI, with labs, and product representatives involved in patient's case through verified unsecured, unencrypted means. The Privacy Rule allows those doctors, nurses, hospitals, laboratory technicians, and other health care providers that are covered entities to use or disclose protected health information, such as X-rays, laboratory and pathology reports, diagnoses, and other medical information for treatment purposes without the patient's authorization. This includes sharing the information to consult with other providers, including providers who are not covered entities, to treat a different patient, or to refer the patient. See 45 CFR 164.506. any source other than your Healthcare Providers, will sign a Business Associate Agreement. Patient understands if permission is not granted, USPS, is the only means f communication with those involved in patient's case, which is considered HIPAA compliant. Treatment may take considerably longer in this case. This office will not be held responsible for any delay in mail which then causes an increase in treatment time or treatment costs. Patients or approved contacts may request and pick up copies of PHI to be hand delivered.

Print Patient's Name:____Date____________________________
Print Legal Guardian's Name____Date____________________________
Signature of Patient or Legal guardian____Date____________________________
________Patient refused to sign HIPAA consent. Patient has the right to refuse, USPS or pick up will be used for PHI transfer.

Office Staff Signature_____________________________Printed Name____________________________________Date___________________

**Witness Signature________________________________Printed Name_________________________________Date____________________